

**CONSOLIDATED BENEFITS (COBEN)
CASH ENROLLMENT ELECTION**

STD. 702 (NEW 4-2000)

COBEN**SEE PRIVACY NOTICE ON REVERSE SIDE****PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY--SEND COMPLETED FORM TO YOUR DEPARTMENT'S PERSONNEL/PAYROLL OFFICE**

1. ENROLLMENT (Check appropriate box)	2. SOCIAL SECURITY NUMBER
A. <input type="checkbox"/> Open Enrollment	3. NAME (First, MI, Last)
B. <input type="checkbox"/> Newly Eligible Enrollment	
C. <input type="checkbox"/> Change in Status Event	
D. <input type="checkbox"/> Cancellation	

COBEN ELECTIONS - QUESTIONS REGARDING THE FOLLOWING PLAN ELECTIONS SHOULD BE DIRECTED TO YOUR PERSONNEL/PAYROLL OFFICE

BENEFIT ITEM	ENTER MONTHLY COBEN CASH AMOUNT	5. For SCO Use Only Type of Change
4. CoBen Cash 354-020	A. Health Only \$ _____ B. Health and Dental \$ _____	

6. STATEMENT OF OTHER HEALTH OR STATEMENT OF OTHER HEALTH AND DENTAL COVERAGE

I certify that I am covered by another health or another health and dental plan as indicated below. I certify that I will maintain coverage in this health or health and dental plan on an ongoing basis and I agree to notify my Personnel Office within 60 days if I lose coverage.

A. HEALTH INSURANCE PLAN NAME	C. OTHER COVERAGE THROUGH (Check one) <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other
B. DENTAL INSURANCE PLAN NAME	D. IF YOUR HEALTH/ DENTAL INSURANCE IS THROUGH YOUR SPOUSE OR DOMESTIC PARTNER, COMPLETE THIS ITEM Spouse's or Domestic Partner's Employer Social Security Number <input type="checkbox"/> State <input type="checkbox"/> Other

7. I UNDERSTAND THAT MY COBEN CASH ELECTION IN LIEU OF HEALTH OR HEALTH AND DENTAL COVERAGE WILL CONTINUE FROM YEAR TO YEAR UNTIL I TAKE ACTION TO CHANGE OR CANCEL MY ENROLLMENT.

IF I AM A PERMANENT INTERMITTENT EMPLOYEE I UNDERSTAND THAT THIS CONTINUOUS ENROLLMENT DOES NOT APPLY TO ME AND THAT I MUST REENROLL EACH YEAR DURING THE ANNUAL OPEN ENROLLMENT PERIOD.

I understand that my benefit elections are regulated under Section 125 of the Internal Revenue Service (IRS) Code. I understand that regulations under the IRS Code require that my benefit choices authorized by this election are irrevocable until the next scheduled open enrollment unless I have a valid "Change in Status Event" as defined in IRS Code Section 125 or other permitting events as defined by the Department of Personnel Administration (DPA).

I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE COBEN CASH ELECTION AS OUTLINED ON THIS ELECTION FORM AND BY DPA.

EMPLOYEE SIGNATURE	DATE SIGNED
	

AGENCY USE ONLY

8. EFFECTIVE DATE OF ACTION MO DAY YEAR -1-	9. EMPLOYEE CBID	10. PERMITTING EVENT DATE MO DAY YEAR	11. PERMITTING EVENT CODE	
12. HEALTH FORM ATTACHED (HBD - 12) <input type="checkbox"/> YES <input type="checkbox"/> NO	13. DENTAL FORM ATTACHED (STD. 692) <input type="checkbox"/> YES <input type="checkbox"/> NO	14. PERMANENT INTERMITTENT <input type="checkbox"/> YES <input type="checkbox"/> NO	15. AGENCY CODE	16. UNIT CODE
17. REMARKS		18. AGENCY NAME		
		19. AUTHORIZED AGENCY SIGNATURE I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency, that I am authorized to make this certification and that the employee named herein is eligible for enrollment in Consolidated Benefits.		
		20. DATE RECEIVED IN EMPLOYING OFFICE (mo) (day) (year)		
		21. TELEPHONE NUMBER (Indicate if CALNET or give area code)		

DISTRIBUTION: Original - State Controller's Office; Pink - Agency; Goldenrod - Employee

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STD. 702 (NEW 4-2000) (REVERSE)

PRIVACY NOTICE

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by the State Controller's Office and the plan administrator for the purposes of identification and document processing.

It is mandatory to furnish all information requested on this form. Failure to provide the mandatory information may result in enrollment elections not being processed or being processed incorrectly.

The State Controller's Office requires employee's social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Sections 1151 and 1153, Sections 6011 and 6051 of the Internal Revenue Code, and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

Copies of the Consolidated Benefits (CoBen) Cash Enrollment Election are maintained in confidential files of the State Controller's Office for five years. Employees have the right of access to copies of their Consolidated Benefits (CoBen) Cash Enrollment Election upon request. Send requests to: State Controller's Office, Personnel/Payroll Operations Branch, P.O. Box 942850, Sacramento, California 94250-5878, Attention: Benefits Unit.